(HI) program and the voluntary Supplementary Medical Insurance (SMI) program that pays for physician services. The latter is financed by premiums (about one-quarter) and an appropriation from general revenues (about three-quarters).

Medicare outlays increased from $7.1 billion in 1970 to $42.5 billion in 1981, an average annual rate of increase of 17.6 percent. Much of the increase in outlays has come from the rising per capita spending on medical care. While the structure of Medicare benefits has changed little since the program's enactment, reimbursements per aged enrollee increased from $334 in 1970 to $1,409 in 1981. This increase, averaging 13.7 percent per year, exceeds by a substantial margin the 8.3 percent annual increase in medical prices during the period. The difference is explained by increasing rates of use of medical services. Rates of hospitalization have increased, and more and more services are delivered during a hospital stay. This phenomenon is not unique to Medicare, but reflects trends affecting the entire medical care system, although many think that Medicare's extensive coverage of hospital care and policy of reimbursement on the basis of cost have contributed to these trends. Growth in the population age 65 and over also contributed.

Expansion of eligibility in 1972 also contributed to growth in spending. 3/ Medicare coverage was extended to disabled persons who had received Social Security or Railroad Retirement benefits for at least 24 consecutive months and to persons suffering from end-stage renal disease. In 1981 reimbursements for care provided to these groups totaled $5.5 billion, or 13 percent of all Medicare reimbursements.

In 1972 the Congress enacted a number of measures designed to slow the rise in Medicare outlays by limiting the amounts of reimbursement to providers and reviewing the appropriateness of use of services. 4/ Savings from these provisions have been relatively modest compared with program outlays.

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3. Social Security Amendments of 1972 (P.L. 92-603).

4. Social Security Amendments of 1972 (P.L. 92-603). The more important provisions are Professional Standards Review Organizations (PSROs), which review the appropriateness of service use; the limits on hospital reimbursements; and the limiting of physicians' reasonable charges through an economic index.

Medicaid. The Medicaid program provides matching funds to states to finance medical care for low-income persons who are in families with dependent children or who are aged, blind, or disabled. Like Medicare, the cost of the program has grown rapidly, especially during its early years. Federal outlays increased from $2.7 billion in 1970 to $16.8 billion in 1981--or at a 9.1 percent annual rate after adjusting for inflation. Growth in the eligible population, and increases in per capita medical spending reflecting medical care system changes, were the principal causes. Increasing use of nursing homes by elderly persons has also been an important factor, especially in recent years. Nursing home and home health care now account for 44 percent of Medicaid costs.

Legislation has played a relatively minor role in Medicaid cost increases. The 1972 Social Security amendments increased eligibility by establishing the Supplemental Security Income (SSI) program, which provides cash assistance to low-income persons who are aged, blind, or disabled. In most states, SSI recipients are automatically eligible for Medicaid. In recent years, however, state governments have been restricting benefits and eligibility within the bounds permitted by federal law, slowing the growth in outlays to some extent.

Medical Care for Veterans and Other Health Care Services. Other federal programs, the largest of which is the Veterans Administration (VA) medical care system, deliver health services to specific populations. Outlays for veterans' medical care increased by 13.1 percent annually between 1970 and 1981, from $1.8 billion in 1970 to $7.0 billion in 1981. This increase is attributed primarily to an increase of 155 percent in the number of patients treated and to increases in the cost of providing medical care. Costs in the VA system were restrained somewhat by a 63 percent decrease in the median length of stay.

The Department of Health and Human Services (HHS) provides care to American Indians and, until recently, merchant seamen. In addition, a large number of categorical grant programs enable state and local governments and private agencies to provide various health services to low-income persons and to conduct public health activities such as immunizations. From 1970 to 1981, federal spending for the HHS delivery programs increased by 10 percent per year, reflecting inflation and growth in the number of programs.

Health Research. Nearly 90 percent of federal outlays for health research support biomedical research at the National Institutes of Health (NIH). The NIH sponsors both basic research on

biological processes and research into the causes and treatment of specific diseases.

Increased federal involvement in biomedical research caused outlays to rise 12.5 percent annually between 1970 and 1981, or 4.3 percent after adjusting for inflation. During this period, research on certain specific diseases received disproportionate increases in funding because high priorities were set on finding cures for them. For example, between 1970 and 1980 the National Cancer Institute's budget increased by 450 percent. In recent years, as overall funding growth has slowed, increases in funding for specific illnesses have become more uniform.

The 1982 Budget Decisions

The 1982 budget decisions cut health programs less than other human resources programs, but the cuts were still of unprecedented magnitude. Health outlays in 1982 will be reduced by $2.8 billion, or 3.6 percent of what they would have been under current policies. 5/ Little attempt was made, however, to solve the underlying problem of rising per capita use of medical services. The most significant policy change was the consolidation of a number of categorical health programs into block grants to the states. These programs also absorbed the largest percentage reductions. Medical care for veterans and health research were affected least.

Nineteen categorical health programs were consolidated into four block grants to the states, and funding for them in 1982 was cut by 33 percent from current policy levels. The deepest cuts were experienced by programs incorporated into the Alcohol, Drug Abuse, and Mental Health block grant. The entitlement to medical care by merchant seamen was discontinued.

Federal grants to the states for Medicaid were cut 3 percent in 1982 (4 percent in 1983 and 4.5 percent in 1984) from what they otherwise would have been. The cuts will be reduced for those states with high unemployment, effective hospital cost control programs, documented fraud and abuse reductions, or very low rates of increase in Medicaid spending. States will also be allowed

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5. The baseline for cuts discussed in this section is the reconciliation baseline projection adopted by the Congress in May 1981. The 1982 funding levels for appropriated programs are those in the current continuing resolution (P.L. 97-92).

substantially more discretion in the areas of hospital reimbursement and coverage of the medically needy. Savings from Medicaid changes will total $0.9 billion in 1982, or 5.2 percent of spending under current policies.

In the Medicare program, cuts were made in both benefits and rates of hospital reimbursement. The amounts paid by the beneficiary before Medicare reimbursements begin (deductibles) were increased in both the hospital and the physician parts of the program. A number of benefit expansions enacted as part of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499) were repealed as part of the 1981 reconciliation act. Hospital reimbursement was lowered by tightening the limits on per diem reimbursement for routine costs and reducing the size of extra payments intended to offset presumed higher nursing costs of Medicare patients. Excluding accounting savings from repeal of a change in the Medicare system of interim payments to hospitals, 1982 savings will total $0.7 billion, or 1.4 percent of spending under current policies.

Baseline Projections, 1983-1987

Federal spending on health is likely to continue to grow more rapidly than the rate of inflation, principally from rising medical care costs. Under current policies, outlays are expected to increase from $84.6 billion in 1982 to $156.5 billion in 1987, an annual increase of 13.1 percent.

Medicare outlays will increase the most rapidly, at an annual rate of 15.7 percent during this period. In addition to rising medical care costs, the aging of the population will be a factor.

Medicaid spending is expected to grow much less rapidly than that for Medicare, but still more rapidly than the general rate of inflation. The eligible population is projected to decline somewhat, although increasing use of long-term care, caused by the aging of the population, will work in the opposite direction. Medicaid spending is also affected by rising medical care costs.

Outlays for veterans' medical care will grow rapidly because of demographic trends. The number of veterans over age 65 will more than double in the decade of the 1980s. Aged veterans are particularly heavy users of the VA medical care system.

BUDGET STRATEGIES

In developing budget reduction strategies for health, the basic federal role--financial assistance to individuals to obtain care in the private medical system--is not in question. Few have suggested that such assistance is not an appropriate federal responsibility. Instead, changes are being sought that would reduce the budgetary costs of continuing this role.

This chapter examines two basic budget strategies for health. One would involve a direct reduction of outlays through shifting responsibility from the federal government to individuals and businesses. The other would involve actions to reduce the cost of medical care, which would indirectly reduce federal outlays. Many specific budget reduction options encompass both strategies--that is, by shifting responsibility in certain ways they would release market forces that would contain health costs.

First, major opportunities for shifting responsibility exist in the Medicare and Medicaid programs and in the tax provisions that relate to medical care. Responsibility for Medicare and Medicaid financing could be shifted to beneficiaries, providers of medical services, to other levels of government, or to a limited extent, employers. 6/ Beneficiaries could be required to pay more, providers could be paid less, employment-based coverage could be required to pay for services that are also covered by Medicare, and the federal government could pay a lower percentage of the costs of Medicaid. Tax benefits could be reduced for those obtaining health insurance through employers or for those using the medical expense deduction.

Second, the federal government has two broad options for reducing medical care costs, which in turn would reduce Medicare and Medicaid outlays and the revenue loss from health care provisions in the tax code. It could take steps to make greater use of market forces in the production and distribution of medical care,

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6. Opportunities to shift responsibility to employers are limited, because few persons receiving benefits from these programs are employed. Very few Medicare beneficiaries are employed full time--and part-time employees are often not covered by the firms' policies. Medicaid already does not pay for services covered by a private insurance policy.

or it could add to the economic regulation of medical care. Either option could include a shift of responsibility away from the federal government as well.

Increased reliance on the market means getting the patient to accept more responsibility for medical care costs. The patient might be required to accept increased cost sharing or to choose among alternative health care delivery systems such as Health Maintenance Organizations (HMOs). In either case, the patient would be given an incentive to reduce the use of services, which in turn would place downward pressure on prices.

Among regulatory options, the most promising is control over hospital revenues. The strategy behind such regulation is to provide hospitals with an economic constraint, one that they do not currently get from the market because third parties, rather than patients, pay for most hospital care. Whether limitations on Medicare and Medicaid reimbursements alone would suffice to provide such a constraint, or whether revenues from all payers must be controlled, is a subject of extensive debate. The federal government could either regulate hospital revenues itself or encourage states to do it. 7/

Shifting Responsibility to Beneficiaries

Requiring beneficiaries to pay more of their medical care costs could lead to substantial budget savings, but the magnitude of such a shift would be constrained by the fact that many beneficiaries cannot afford additional out-of-pocket expenses. Medicaid recipients all have very low incomes. Some Medicare beneficiaries are better off, however, and could pay somewhat more out-of-pocket for medical services.

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7. Contrary to common belief, the federal experience with economic regulation of medical care has been very limited. Except for the period of wage and price controls during the early 1970s, neither physicians' fees nor hospital rates have been regulated at the federal level. Federal law (P.L. 93-641) does require states to conduct certificate-of-need review of major hospital capital projects, but the deadline for compliance is still in the future.

One way of dealing with this constraint would be to exempt those with the lowest incomes from the requirements of higher out-of-pocket spending. This would keep reductions in access to medical care to a minimum and would concentrate burdens on those most able to bear them. A means test of this sort for Medicare services would encounter opposition, however, on the grounds that Medicare is a social insurance program. Another consideration would be the administrative costs involved in assessing financial need.

Among the different ways of reducing outlays by shifting responsibility to beneficiaries, some would also stimulate market forces that would act to contain medical costs. In general, requiring beneficiaries to pay more for the services they use would tend to contain medical costs, while raising the premiums they pay for coverage would not.

Alter the Pattern of Hospital Coinsurance under Medicare. Under current law, beneficiaries pay a deductible amount equal to the estimated average cost of one day's hospitalization, but have no other cost sharing until the sixty-first day of hospitalization during a spell of illness, at which point coinsurance begins. Such extensive coverage does not provide much incentive to limit hospital use.

Beneficiaries could be required to pay 10 percent of the cost of the current deductible for the second through thirty-first day in a calendar year--about $26 per day in 1982 (see Appendix A-550-b). Some of the savings from this coinsurance charge could be used to limit patient liability for hospitalization by expanding Medicare coverage to all hospital charges beyond the first 31 days of hospitalization in a calendar year. The net reduction in federal outlays would be $1.1 billion in 1983 and $7.4 billion over the 1983-1987 period. State Medicaid outlays would increase, however, since Medicaid would pay the additional coinsurance for those Medicare beneficiaries also eligible for Medicaid.

The proposal would reduce rates of use of hospital services for those not receiving Medicaid or not covered by private supplemental insurance. This in turn would pressure hospitals to contain costs. While the proposal would improve protection against the risks of very large expenses, some beneficiaries with low incomes might be adversely affected.

If additional budget reductions in the Medicare program were sought, the coinsurance rate could be increased further. In that case, consideration might be given to limiting the additional cost sharing to those beneficiaries with relatively high incomes--in effect, partially means testing Medicare benefits.

Tax Private Insurance that Supplements Medicare. Over half of all Medicare beneficiaries purchase (or receive from employers) private coverage to supplement Medicare. Many of these plans pay the deductibles and coinsurance required of Medicare beneficiaries, so that in effect they have full coverage for hospital and physician services.

Medicare implicitly subsidizes these supplemental policies, because it pays a large portion of the costs of additional use of services that they generate. Adding supplemental benefits to Medicare results in about a 7 to 10 percent increase in service use--and Medicare pays most of these costs (for example, 80 percent of physicians' reasonable charges).

By taxing supplemental plans, the federal government could recoup this unintended subsidy to those purchasing supplemental coverage (see Appendix B-550-e). Federal savings would come both from tax collections and from reduced service use by those deciding to discontinue supplemental coverage; savings would amount to $2.5 billion in 1983 and $17.7 billion over the 1983-1987 period.

This option would, like the coinsurance option, reduce the use of medical services, but its distributional impact would be different in that it would affect only those Medicare beneficiaries with supplemental coverage. Such persons would tend not to be the beneficiaries with the lowest incomes, who would be most adversely affected by the coinsurance option.

Increase Medicare Part B Premiums. When originally enacted, Part B of Medicare--which covers physicians' services--was to obtain 50 percent of its financing through premiums paid by the beneficiaries. In 1972, percentage increases in premiums were limited to the cost-of-living adjustment for Social Security benefits. With medical care costs rising rapidly, the proportion of Part B expenses financed by premiums declined to 25 percent in 1981, and will continue to fall.

Raising the percentage to 30 percent would increase receipts from premiums (and reduce required transfers from general revenues) by $1.0 billion in 1983 and $11 billion over the 1983-1987 period

(see Appendix B-550-d). Under such an option, premiums for 1982-1983 would increase to $14.90 per month, an increase of $2.70 per month from the level projected under current law. In contrast to the previous two options, raising premiums would have little effect on medical care costs.

Since the poorest Medicare beneficiaries are also covered by Medicaid, which usually pays Part B premiums on their behalf, this option would not affect them. It could be burdensome to those whose incomes are only slightly higher than SSI eligibility levels, however. States' responsibility for the premiums of Medicaid recipients would increase their outlays by roughly 8 percent of the amount saved by the federal government.

Shifting Responsibility to Medical Providers

The long-term potential for budget savings from reducing payments to providers would depend upon the extent to which the providers were given opportunities to avoid reductions in net income by lowering their costs. If the design of the cut did not permit such opportunities, risks of a significant reduction in access to care by the beneficiaries would limit the extent to which reimbursements could be cut.

In hospital reimbursement, Medicare and Medicaid already pay substantially less than other payers. Investment bankers report that hospitals with large Medicare and Medicaid caseloads tend to be shunned by lenders. Further reimbursement reductions could impair the ability of these hospitals to modernize their plant and equipment, or even to continue to operate. On the other hand, options such as prospective reimbursement of hospitals could ultimately lead to large budget savings without injuring hospitals if they were successful in spurring hospitals to reduce costs.

In physician reimbursement, on the other hand, a reduction in rates in Medicare would be to some extent equivalent to a reduction in benefits, since many physicians would compensate by requiring patients to pay more. In Medicaid, where physicians must accept the program's reimbursement as payment in full, physician participation would decline further.

Expand Medicare Hospital Routine Cost Limits to Include Ancillary Services. Currently, Medicare reimbursements for routine costs (nursing and room and board services) are limited to 108 percent of mean per diem costs in groups of similar hospitals. Such

limits give high-cost hospitals incentives to reduce costs. But most analysts feel that the nub of the hospital problem lies in ancillary services such as laboratory tests and X-rays, a component of costs to which current reimbursement limits do not apply.

Limiting reimbursement to 110 percent of the group mean for total operating costs (adjusted for diagnostic mix) would give high-cost hospitals incentives to contain ancillary as well as routine costs (see Appendix A-550-c). Federal savings would be modest in 1983 because of start-up delays, but would total $5 billion over the 1983-1987 period.

This option would reduce hospital costs to some extent, although some of the reimbursement reduction would be borne by other payers or by the hospital itself. Some hospitals would find it much easier to make up for the reimbursement reduction by raising charges to private patients rather than reducing costs. Those facing relatively large reimbursement reductions would not be able to reduce costs by as much, at least initially.

Give Incentives to States for Hospital Cost Containment. Currently, six states have mandatory programs that limit hospital rates or revenue. As a group, these programs have been quite successful in slowing the rise in hospital costs, although some observers contend that the savings have come at the expense of the quality of care. The federal government has benefited substantially from the success of these programs, through lower Medicare and Medicaid reimbursements to hospitals.

Offering the states a share of the savings the federal government realizes from their programs could induce additional states to pursue such efforts, and ultimately further reduce federal outlays for Medicare and Medicaid (see Appendix A-550-d). While estimates of savings depend upon the number of states induced to develop programs, giving states one-third of the Medicare savings could reduce federal outlays by $1.5 billion over the 1983-1987 period. States initiating programs would gain substantial amounts through both the incentive payments and Medicaid savings.

Shifting Responsibility to Other Levels of Government

The federal government in 1982 will pay about 55 percent of the cost of Medicaid through matching grants to the states. This rate was reduced from 56 percent by the 1981 reconciliation act. An argument against shifting further responsibility in this direc-

tion is that the state and local governments are not in a position to absorb significant additional burdens. A significant shift could seriously restrict states in their abilities to provide essential services without raising their tax rates, or force them to impose major cuts in Medicaid eligibility and benefits. One option with some potential would be to cap federal grants to states for Medicaid for long-term care.

Cap Medicaid Grants for Long-Term Care. Medicaid expenditures for long-term care have grown very rapidly, and now represent 44 percent of Medicaid expenditures. A formula-determined ceiling on federal grants for long-term care expenditures, coupled with increased discretion for states to manage the delivery of long-term care services, would save federal dollars--about $3.4 billion over 1983-1987--and could lead states to reduce health costs (see Appendix A-550-a).

The extent to which such a change in funding would reduce health costs rather than merely shift responsibility to the states would depend upon states' potential to reduce their Medicaid outlays for long-term care, given additional discretion and incentives. While some are enthusiastic about the prospects for economizing through substituting home-based services for nursing home care, an important obstacle to outlay reduction is the likelihood that some of the beneficiaries of increased funding for home-based services would not have been institutionalized in any event. In addition, nursing home capacity constraints in some states are such that beds vacated by patients newly treated at home would be filled by others on a waiting list. If states were not able to reduce their long-term care outlays under Medicaid, then this option would become primarily one of shifting responsibility.

Shifting Responsibility to Taxpayers

In contrast to the Medicare and Medicaid programs, whose benefits are targeted toward the elderly and the poor, tax provisions affecting spending for medical care are not specifically targeted; they benefit middle- and upper-income persons most. The following options would shift some responsibility to taxpayers. The first would also work to contain medical care costs by increasing cost sharing and enrollment in HMOs.

Tax Some Employer-Paid Health Insurance. Employees do not pay taxes on income received in the form of employer-paid health care coverage. This exclusion will reduce federal revenues by

about $25 billion in 1983. One proposal for limiting the present exclusion would treat as taxable income any portion of employer contributions exceeding $150 a month for family coverage and $60 a month for individual coverage in 1983, with the amount indexed thereafter to medical care prices (see Appendix B-550-b). The proposal would increase revenues by $2.6 billion in 1983 and $27 billion over five years.

Limiting the exclusion would reduce the comprehensiveness of employer-provided health insurance benefits. By limiting the special treatment of employer contributions, the incentive to shift employee compensation from cash to health insurance would be reduced. Less health insurance would induce employees to economize on their use of health services, which in turn would slow medical cost increases.

If larger revenue increases were desired, either the ceiling could be lowered, or a smaller inflation adjustment used. Eliminating the exclusion altogether would raise much larger amounts of revenue--$18 billion in 1983 for example.

Tighten the Medical Expense Deduction. The 35 percent of taxpayers who itemize may claim as deductions all out-of-pocket medical expenses that in total exceed 3 percent of adjusted gross income (AGI). Raising the threshold to 15 percent of AGI would add $0.4 billion to revenues in 1983 and $14 billion over the next five years (see Appendix B-550-a).

The argument for tightening the deduction is that it does little to increase access to basic medical care. In contrast to 1942, when the provision was first introduced into the tax code, most persons today have health insurance to finance medical care. For those who do not, and whose incomes are insufficient to purchase medical care, the deduction gives only minimal assistance.

CONCLUDING COMMENTS

Federal spending for health has increased rapidly in recent years, primarily because of developments in the medical care system. That system now delivers more medical services per person than in earlier years, and at higher costs. Since federal programs serve primarily to finance people's access to medical care, budget outlays have risen correspondingly.

Both of the budget reduction strategies discussed in this chapter would maintain the basic federal role in financing medical care for the needy. The first strategy would enable the federal government to shift some of the financial responsibility to beneficiaries, medical care providers, other levels of goverment, or taxpayers who benefit from tax expenditures for medical care. The other strategy would work to slow the rise in medical costs, either by stimulating market forces or through economic regulation of medical care--steps that hold the greatest promise of reducing federal spending on health in the long run. Some of the options discussed have important elements of both strategies.

CHAPTER X. INCOME SECURITY

Federal income security programs, mostly under budget function 600 and a few under function 700, provide assistance to broad segments of the population. Most such aid takes the form of social insurance for retirement, disability, and unemployment. Social Security, the largest such program, alone accounted for more than one-fifth of the total U.S. budget in 1981. Other social insurance programs under income security include veterans' compensation, retirement and disability benefits for federal employees, compensation for victims of black lung disease, and a portion of unemployment compensation.

Besides social insurance, income security programs provide "means-tested" benefits to low-income families. Some means-tested benefits are directed toward specific consumption activities through the Food Stamp, energy assistance, and various child nutrition and housing assistance programs. Means-tested cash assistance programs are Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), veterans' pensions, and the Earned Income Tax Credit.

Although not part of the income security category, many other provisions in the tax code--such as the extra personal exemption for the aged and blind--also extend income support to individuals. Possible changes in these tax provisions are discussed in Chapter XII.

BUDGET HISTORY AND PROJECTIONS

Federal spending for income security has grown dramatically over the last decade. Starting from 25 percent of total federal outlays in 1970, income security programs now constitute one-third of all federal spending--about $238 billion in 1981. The growth of some of these programs is summarized in Table X-1. The food and housing assistance programs increased at the most rapid rate during the 1970s, although together their outlays totaled less than $23 billion in 1981. Social Security, the most important contributor to growth in dollar terms, increased more slowly than the food and housing assistance programs although at a faster rate than either AFDC or SSI.

TABLE X-1. FEDERAL OUTLAYS FOR INCOME SECURITY PROGRAMS (In billions of dollars)

Major Programs	Actual 1970	Actual 1981	Estimated 1982	Baseline Projection 1983	Baseline Projection 1987
Social Insurance					
Social Security retirement	27.3	122.3	139.3	153.6	214.2
Social Security disability	3.0	17.3	18.8	20.0	23.5
Veterans' pensions	2.3	3.8	3.6	3.5	3.5
Veterans' disability compensation	3.0	8.5	9.5	10.4	14.0
Civil Service retirement a/	2.7	17.7	19.8	22.0	31.6
Means-Tested Programs					
AFDC	2.2	8.5	8.1	8.3	9.9
SSI	1.9	b/ 7.2	8.0	9.1	10.6
Food Stamps	0.6	11.3	11.5	12.5	15.7
Other nutrition programs	0.6	5.0	4.6	4.9	6.6
Housing assistance programs	0.5	6.8	8.3	9.8	16.0
Other Social Insurance and Means-Tested Programs c/	4.2	29.6	34.5	32.5	33.3
Pay Raises d/	---	---	---	0.1	0.3
Total	48.3	238.0	266.0	286.7	379.2

a. Civil Service retirement is discussed in Chapter XI.

b. Based on total federal outlays for Aid to the Blind, Aid to the Aged, and Aid to the Permanently and Totally Disabled.

c. This category includes smaller income security programs such as black lung disability, the federal share of unemployment insurance, and the Earned Income Tax Credit.

d. See Table IV-1, footnote a, for distribution of pay raises.

Historical Trends, 1970-1981

Economic factors are particularly critical in explaining the rise in income security outlays over the last decade. The combination of inflation and program indexation (that is, automatic cost-of-living adjustments, or COLAs) brought about much of the growth. Indexation translates increases in consumer prices into higher

nominal benefit levels. 1/ In the income security area, these economic forces have had an especially great influence on the Social Security program, putting extreme pressure on the trust funds that finance the system. In addition to inflation, high unemployment rates contributed to outlay growth.

Other factors explaining the trend in income security outlays are legislative and demographic changes. Legislative actions prompted high growth rates of outlays through expanded coverage and benefits under existing programs and the introduction of new programs. Also, since many income security programs are "entitlements," with eligibility and benefit amounts determined according to fixed provisions of law, demographic changes have increased the number of persons qualifying for benefits during the 1970s.

Economic Factors. High rates of inflation contribute to growth in income security through the indexation of benefits. Most COLAs were introduced by the early 1970s, although their impact became more important as rates of inflation increased late in the decade. Social Security, railroad retirement, federal civilian and military retirement, SSI, veterans' pensions, and food stamps and most child nutrition benefits are currently adjusted automatically for inflation; much of these programs' growth can be attributed to this indexing. Together, these programs account for nearly 80 percent of income security outlays.

In addition, since nominal wages tend to rise steeply during periods of inflation, so do retirement, disability, and unemployment compensation benefits based on earnings. This has been particularly important for Social Security. Finally, to maintain real benefit levels, benefits in unindexed programs are often increased on an ad hoc basis in periods of inflation.

Unemployment rates also critically affect the costs of many income security programs. Increases in the level of unemployment raise both participation in unemployment insurance and the duration of the benefit period. To a lesser extent, high unemployment rates

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1. Unless otherwise specified, all amounts are shown in current (nominal) dollars. Consequently, some nominal increases in benefits may actually represent a decline in purchasing power (as measured by "real" changes in benefits). If benefits were perfectly indexed for inflation, real benefits would remain constant.

also increase participation in food stamps and AFDC, and may raise enrollment in disability and retirement programs (including Social Security). In the 1970s, unemployment averaged 6.2 percent a year, whereas the annual average in the 1960s was 4.8 percent.

Legislative Changes. A number of legislative changes have also contributed to escalation in program costs. During the 1970s, the Congress increased benefits, liberalized eligibility standards, and introduced a number of new means-tested programs.

Through the 1960s and early 1970s, rules governing eligibility and benefit levels for social insurance programs were liberalized, resulting in expanded participation. For example, the easing of administrative rules under the Social Security disability program probably contributed to the growth of disabled workers' enrollment from 1.4 million in 1970 to 2.9 million in 1979. Moreover, in 1972, the Congress raised Social Security benefit levels substantially. The increases from this change more than compensated beneficiaries for changes in prices since the previous increase, which occurred in January 1971.

During the 1970s, several new means-tested programs were enacted. In 1974, the federal SSI program replaced Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled--programs with costs shared by the states. Although the categories of persons eligible for assistance did not expand under SSI, the federal government accepted responsibility for providing a standard, nationwide benefit level, resulting in larger benefits for many participants and an easing of states' welfare burdens.

Although food assistance programs have existed in some form for more than five decades, major administrative modifications in 1969 effectively created a new Food Stamp program that was then incorporated into one nationwide program in the mid-1970s. Partly because of the relaxation of certain regulations (such as elimination of the purchase requirement), the Food Stamp program has expanded substantially. The number of food-assistance beneficiaries rose from 14.3 million in 1971 to 21.8 million by 1980.

Another new income security program, the Earned Income Tax Credit, aids low-income families either by reducing the taxes they owe or by offering direct payments to those with no tax liability. The direct-payment portion of the credit is considered part of the income security function. This program provides benefits for the working poor with dependent children, a group with little other federal assistance.

Demographic Shifts. The aging of the population has contributed significantly to the growth in income security outlays over the past decade. Between 1970 and 1980, the number of persons aged 65 or older grew by 28 percent, compared to only a 10 percent increase in the number of persons under 65. Outlays for Social Security and SSI are sensitive to the greater number of elderly. In addition, the trend toward early retirement also augmented Social Security outlays over this period.

Changes in the structure of the American family have expanded the roles of other income security programs. Rising divorce rates and numbers of single mothers led to an increase in the number of households headed by women. Such families have lower-than-average incomes, which makes them more likely to be eligible for AFDC. The proportion of families receiving AFDC benefits increased over the decade, from 3.7 percent of all U.S. families in 1970 to 6.5 percent in 1980.

The 1982 Budget Decisions

The Congress' 1982 budget decisions will reduce income security outlays by approximately $10 billion from the original CBO baseline estimate for 1982. 2/ Although this will lower spending for nearly every income security program, the means-tested programs will be affected to a greater extent than social insurance. The AFDC, Food Stamp, and child nutrition programs will undergo large reductions, while relatively small cuts were made in SSI and veterans' programs. Social Security retirement and disability will account for only 17 percent of outlay savings, although this program will represent an estimated 59.4 percent of all income security outlays in 1982.

Budget reductions in the social insurance area focused on relatively small adjustments in programs. The largest change (in dollar terms) will phase out the postsecondary student benefit program funded by Social Security. Current student beneficiaries will face substantial reductions in payment levels and anyone who is not a full-time postsecondary student before May 1982 cannot qualify for the program at all. Another important change in Social Security is the elimination of the Social Security minimum benefit

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2. The baseline for cuts discussed in this section is the reconciliation baseline projection adopted by the Congress in May 1981.

for virtually all new recipients. Other reductions, such as the imposition of a so-called "megacap" on new public disability awards, have been instituted to reduce duplicate benefits.

Most of the changes in income security affect the means-tested programs. A large portion of savings will be achieved simply by reducing the level of benefits or services provided. More stringent income and other eligibility standards will be imposed for AFDC, food stamps, and child nutrition, particularly limiting participation by the working poor and persons just below the poverty line. For example, the AFDC program will now reduce benefits by $1 for every $1 earned after four months of employment, which will affect both levels of benefit payments and numbers of beneficiaries. Administrative adjustments such as retrospective monthly accounting for the AFDC, SSI, and Food Stamp programs will contribute to ensuring that benefits change quickly in response to changes in participants' incomes.

Overall, the federal share of AFDC benefits was cut by $659 million and the food and nutrition assistance programs--including food stamps and child nutrition--were reduced by about $3.2 billion. Funding for low-income energy assistance has been reduced by $495 million, which is a cut of 22 percent compared to the original CBO baseline. Housing assistance was cut back by reducing the number of additional subsidy commitments funded for 1982 and by raising the rent payments of tenants in federally subsidized housing from 25 to 30 percent of household income over the next five years (see also Chapter VII).

Baseline Projections, 1983-1987

By 1987, income security outlays are projected to reach $378.9 billion--a 32.2 percent increase from 1983. 3/ Much of this growth will arise from the COLAs, which automatically raise benefit levels for many of the income security programs. Indeed, several of the programs are projected to experience declines in the number of beneficiaries over the five-year period.

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3. This figure includes all of function 600 and veterans' pensions and compensation from function 700. The figures in this section do not, however, include estimated pay increases for the out-years (1983-1987), which are projected to total $0.3 billion in 1987, since these pay raises have not been allocated across separate programs.